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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

Verification of Physician License

Use a separate form for each state in which you have ever been licensed to practice medicine. Forward to the other state jurisdiction(s) or Licensing Authority for their completion.

Name of Licensing Authority: _____	Applicant's Name: _____
_____	Address: _____
Address: _____	City/State/Zip: _____
City/State/Zip: _____	Telephone Number: _____

This section is to be completed by the applicant.

Don't forget to sign the form.

Last Name: _____ First Name: _____

SSN: _____ License Number: _____

DOB: _____

Name if Different from Above: _____

I am applying for licensure as a Physician in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the State of Delaware Board of Medical Practice. **This includes any medical training licenses.**

Signature: _____ Date: _____

To be completed by the Licensing Authority

Our records indicate that _____ was Licensed in the State/Province/
(Type or print individual's name)

Jurisdiction of _____, on _____
(MM/DD/YY)

and was issued License Number _____.

Expiration Date: _____ Has any discipline activity taken place regarding this licensee?
(MM/DD/YY)

Yes_____ No _____

If an action has been taken, please enclose a certified copy of the Board Order when returning this license verification to the Delaware Board of Medical Practice.

Certification

*****AFFIX OFFICIAL SEAL HERE**

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name:_____ Signature:_____

Title:_____ Date of Signature: _____

Tel: _____ Fax: _____ E-mail: _____

*****RETURN COMPLETED FORM WITH SEAL AFFIXED TO THE BOARD ADDRESS ABOVE. THANK YOU. DO NOT FAX.**